

PAGE 1 - This Health Profile form should open in Adobe Reader. Save this original file to your computer. Next we recommend you Save this file again but Rename it to include the User's name or initials. Fill out this 2-page form by clicking in the areas you wish to fill out. **Re-Save** frequently while filling it out. To Print, go to the print dialogue box and **UN**check the grayscale B&W option. Click the "Printer" tab at bottom, check box for "2-sided" or "Print on both sides of paper." Specify "Short-Edge binding" or "Flip on Short Edge." **Print.** Trim on dotted lines, fold into a tri-fold, insert into your MediPal ID holder and secure to the user's seatbelt.

Thank you for being a part of the MediPal ID family. Take good care.

The MediPal[®] Seatbelt ID

Saving Time Saves Lives

MediPal Inc.



My Personal Information:



Place a photo
of my face here.



My Name: _____

My Nickname: _____

My Date of Birth: _____

My Address: _____

My Home Phone: _____

My Cell Phone: _____

My Pet(s) & location: _____

Location of my Health Care Directive: _____

Family's meeting place away from home: _____

My Emergency Contacts:

(Consider listing one out-of-town contact.)

Parent/Caregiver 1:

Phone: _____

Parent/Caregiver 2:

Phone: _____

My Healthcare Power of Atty.: name/phone

My Automobile Insurance Company:

Name: _____

Phone: _____

Policy #: _____

My Medical Insurance Company:

Name: _____

Phone: _____

Member I.D.#: _____

My Primary Doctor:

Name: _____

Phone: _____

My Specialty Doctor:

Name: _____

Phone: _____

My Dentist:

Name: _____

Phone: _____

This is a screen-fillable PDF form. Find it here:

www.medipal.com/insert-card-uf



The purchaser/user assumes full responsibility for the accuracy of information provided, the placement of the MediPal[®] ID on user's safety belt or physical self, and/or any harm produced by the MediPal[®] ID itself or from any contents placed in or attached to the MediPal[®] ID.
Information provided which results in disclosure of information to unwanted parties or resulting in identity theft is the sole responsibility of the purchaser/user.

Thank you for being a part of the MediPal ID family. Take good care.

My Diagnosis:

- Autism Nonverbal
- Mild Mild/Mod Mod/Severe Severe

UF Center for Autism
and Related Disabilities
UNIVERSITY of FLORIDA



Other Medical Condition(s):

My Primary Language is: _____

- I Communicate By: Voice Sign Language Gestures
 Picture ICONS Written Word Communication Device Interpreter

My typical behaviors may include: 

Motivators to positive behavior are:

Causes of negative behavior are:

Coping strategies are: 

My Medical Information:

My Blood Type: _____

My Weight: _____ My Height: _____

- Hearing loss Wear hearing aids
 Vision loss Wear Glasses/Contacts

My Medications:

As of this date: _____
(Include Names and Dosages of all prescriptions, herbal and homeopathic medicines.)

My Pharmacy name: _____

Phone: _____

Received Covid Vaccine: Yes No

Pfizer Moderna Other: _____

My Allergies to food or medication:
(Include side effects)

My Preferred Hospital:

